

SCHOOL BASED VACCINE REPORTING FORM

For more information on this form contact: 519-258-2146 Ext. 1121 or vaccine@wechu.org

Submit this completed form and required attachments to: Fax: (519) 977-1711 or vaccine@wechu.org

HEALTH CARE PROVIDER INFORMATION

Date: _____

Health Care Provider: _____

Contact Name: _____

Phone #: _____

Fax #: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Vaccine Administered	Date	Lot #	Expiry Date
<input type="checkbox"/> Nimenrix or Menactra			
<input type="checkbox"/> Hepatitis B			
<input type="checkbox"/> Gardasil-9			